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Communi-Care for Migrants and Ethnic Minorities

4th Conference on Migrant and Ethnic Minority Health in Europe

21-23 JUNE 2012, UNIVERSITÀ BOCCONI, MILAN, ITALY



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Inequalities in health and equity in access to health care services by the immigrant population

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Health inequalities across socioeconomic groups are a health and public policy concern in all countries, being considered a measure of performance of health care systems. As reported by the WHO in the World Health Report 2000, improving the health attainment of the population is a main goal in any health care system, together with improving responsiveness to population needs and fairness of financing. At the European level, socioeconomic inequalities in health and health care use are particularly important given not only the challenges posed by the European Union enlargement but also by an aging population.

At the European level, the Member States of the European Union took a major initiative by making the fight against poverty and social exclusion as one of the central elements in the modernisation of the European social model in the European Councils in Lisbon and in Nice (2000). This initiative was made possible on the basis of Articles 136 and 137 of the Amsterdam Treaty. The Lisbon strategy acknowledges the importance of poverty reduction and elimination of social exclusion as mechanisms necessary for the European Union to become the most competitive and knowledge-based economy. A set of common objectives to be pursued by the Member States were established: to facilitate participation in employment and access by all to resources, rights, goods and services; to prevent the risks of exclusion; to help the most vulnerable, and to mobilize all relevant bodies.

At international level, the Commission on Social Determinants (WHO, 2008) was created, recognising the poor health of the poor, the social gradient in health within countries and the existence of health inequities between countries and this is linked to the results of a combination of poor social policies and programmes, unfair economic arrangements and bad politics. It is concluded by the Commission that action on the social determinants of health must involve the whole of government, civil society and local communities, business and

international agencies. Three broad sets of recommendations are suggested to close the gap in health inequities have been provided by the Commission: improving daily living conditions, this is, housing, early child development, health care and social protection; tackling the unequal distribution of resources; and finally, measuring and understanding the problem.

Although there is an overall concern for health inequalities, there is also a substantial amount of evidence on the level of health inequalities across countries. Recent work has shown that significant inequalities favouring the better-off exist in EU member countries and that socioeconomic factors such as education, income and job status have a substantial effect on the health of individuals (Mackenbach, 2006; CSDH, 2008; Hernández-Quevedo et al, 2006, 2008, 2010). Robust epidemiological and economics methodological tools are available to measure inequalities in health across countries, but, there are also numerous methodological issues that the comparative study of health inequalities presents.

Methods based on concentration curves and concentration indices have been extensively used for measuring inequalities and inequities (Wagstaff and van Doorslaer, 2000). The health concentration curve (CC) and concentration index (CI) provide measures of relative income-related health inequality (Wagstaff, Van Doorslaer and Paci, 1989).

Less evidence is available on the existence of socioeconomic related inequalities in health and equity in health care access for the migrant population across Europe. An example of application of these methods to analyse the levels of socioeconomic inequalities in health status and equity of health care utilisation between the migrant population is provided in this lecture, using as an example the Spanish experience. In Spain, immigration is a relatively new phenomenon with growing importance. In the period from 1998 to 2007, the proportion of foreigners registered in the census as a proportion of the total population has increased fivefold, with non-Spanish nationals representing 1.6% of the Spanish population in 1998 and 10% in 2007 (INE, 2008a). This has led Spain to become the main recipient of immigration flows in Europe (Eurostat, 2008). The importance of the phenomenon of immigration for health services was manifested in the approval of the Law 4/2000 of 11th of January about rights and liberties of foreigners in Spain, according to which all individuals, regardless of their nationality, are entitled to use health care services under the same conditions as Spanish citizens (Durán, Lara, & Van Waveren, 2006). The only requisite for immigrants, whether legally accredited or not, to access health care services in the same way as Spaniards is that they should be registered in the local population census. Immigrants who are not registered in the population census are only covered by emergency services. Children and pregnant women have full coverage irrespective of their legal and administrative situation. In addition, the government has recently approved the

"Citizenship and Integration Strategic Plan 2007–2010", which targets the whole population and intends to promote social cohesion through policies based on equality of opportunity and equality of rights and duties (Mladovsky, 2007). Also, the Regional Immigration Plans in most of the Autonomous Communities include as a priority the reduction of inequalities in health and in access to health services. However, these policies have been formulated without any sound scientific evidence corroborating the existence of such inequalities.

Evidence from these applications show that there are different patterns in the level of health and the medical care use between the national and the foreign population in Spain, which are consistent with the international literature: while immigrants' self-reported health relative to that of the Spanish population depends upon individual nationality, all immigrants, regardless of their nationality, seem to face barriers of entry to specialized care. Potential barriers to access to health care services by the migrant population may be related to the own characteristics of this group of the population (e.g., cultural differences in health perception, communication problems among doctor and patient, the socioeconomic context and legal situation) or with factors related to the provision of health care services (e.g., administrative barriers), as well as the attitudes of the health care personnel. A greater knowledge of these barriers would provide an appropriate assignation of resources according to the needs of the population, improving the efficiency of the health care sector.